

AIDS Orphans and Vulnerable Children (OVC): Problems, Responses, and Issues for Congress

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Summary

Since HIV/AIDS was discovered in 1981, more than 20 million people have lost their lives to the virus. According to the Joint United Nations Program on HIV/AIDS (UNAIDS), nearly 40 million are currently living with HIV/AIDS, including nearly 2.2 million children under the age of 15. In 2004, 4.9 million people acquired the virus, and 3.1 million died from AIDS. Sub-Saharan Africa remains the most affected region with 25.4 million people living with HIV/AIDS at the end of 2004, 1.9 million of whom were children under the age of 15. The United States Agency for International Development (USAID), the United Nations Children's Fund (UNICEF), and UNAIDS estimate that at the end of 2003, 15 million children under the age of 18 had lost one or both parents to AIDS, with the majority (82%) in sub-Saharan Africa. In just two years, from 2001 to 2003, the global number of children orphaned by AIDS increased from 11.5 million to 15 million. By 2010, it is expected that more than 25 million children will be orphaned by this deadly virus. Due to the 10-year time lag between HIV infection and death, officials predict that orphan populations will continue to rise for a similar period, even after the HIV rate begins to decline. Experts say only massive spending to prolong the lives of parents could be expected to change this trend.

The impact of HIV/AIDS on children is just beginning to be explored. Not only are children orphaned by AIDS affected by the virus, but those who live in homes that have taken in orphans, children with little education and resources, and those living in areas with high HIV rates are also impacted. Children who have been orphaned by AIDS may be forced to leave school, engage in labor or prostitution, suffer from depression and anger, or engage in high-risk behavior that makes them vulnerable to contracting HIV. Children who live in homes that take in orphans may see a decline in the quantity and quality of food, education, love, nurturing, and may be stigmatized. Impoverished children living in households with one or more ill parent are also affected, as health care increasingly absorbs household funds, which frequently leads to the depletion of savings and other resources reserved for education, food, and other purposes.

Congress passed P.L. 108-25 ("The United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003") in the 108th Congress, which authorizes 10% of HIV/AIDS funds to be used for children orphaned or made vulnerable by the virus. In the 109th Congress, H.R. 1408, "Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2005," passed the House and Senate on October 18, 2005, and October 25, 2005, respectively. Ultimately, the bill was enacted on November 8, 2005. The act, P.L. 109-95, established a monitoring and evaluation system to measure the effectiveness of related assistance activities; directed the appointment of a Special Advisor for Assistance to Orphans and Vulnerable Children within USAID; and required an annual report on project implementation. This report explores some of the challenges facing children affected by HIV/AIDS, outlines U.S. and international efforts to assist those children, and outlines some key issues that may be considered by Congress in the 109th session. This report will be updated.

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Introduction

Since HIV/AIDS was discovered in 1981, more than 20 million people have lost their lives to the virus. Nearly 40 million people are currently living with HIV/AIDS, including nearly 2.2 million children under the age of 15. Ninety-five percent of those living with HIV/AIDS reside in developing countries. Sub-Saharan Africa remains the most affected continent with 1.9 million of the 2.2 million infected children.¹ A joint study conducted by the U.S. Agency for International Development (USAID), the United Nations Children's Fund (UNICEF), and the Joint United Nations Program on HIV/AIDS (UNAIDS) found that at the end of 2003, 15 million children under the age of 18 had lost one or both parents to AIDS, with 12.3 million of them found in sub-Saharan Africa.²

Between 1990 and 2003, sub-Saharan Africa's population of children orphaned by AIDS increased from less than 1 million to more than 12 million³. Due to the 10-year time lag between HIV infection and death, experts predict that without the availability of anti-retroviral medications orphan populations will continue to grow for at least two decades after a country has reached its peak HIV infection rate. In Uganda, for example, although the epidemic has been on a steady decline, from 14% in the late 1980s to 4.1% in 2003, the number of orphans under the age of 15 continued to climb for 10 years after the country's infection rate peaked. Experts report that the number of orphans is only now expected to decline in the country, from 14.6% of Ugandan children in 2001 to a projected 9.6% in 2010.⁴ Thailand, long hailed for having significantly reduced its HIV/AIDS rate, is still witnessing an increase in children orphaned by AIDS. In 1995, there were 63,000 children who had lost their parents to AIDS. In 2001, the number increased to 289,000, and in 2005, an estimated 380,000 are expected to lose their parents to AIDS.⁵

The term "AIDS orphans" is used in the title of this report to facilitate recognition of the issue. However, those that serve children affected by HIV/AIDS caution against the use of this term because they believe it further stigmatizes the children. Consequently, the terms "orphans and vulnerable children" (OVC), "children affected by AIDS," and "AIDS-affected children" will be used hereafter to refer to "AIDS orphans."⁶

The growing population of children orphaned by HIV/AIDS is a concern, because had it not been for HIV/AIDS, the global percentage of orphans would be declining instead of increasing. By the end of 2003, 43 million children (12% of all African children) were orphaned in sub-Saharan Africa, 12.3 million (32% of all African orphans) of those were due to AIDS. Although Asia had a lower number of children orphaned by AIDS in 2001, 1.8 million (2.8% of all orphans), it had a much larger overall orphan population than sub-Saharan Africa, with 65 million orphans.⁷ Some

¹ UNAIDS and World Health Organization (WHO), *AIDS Epidemic Update: December 2004*. Geneva: 2004, p.1.

² UNAIDS, UNICEF, and USAID, *Children on the Brink 2004: A Joint Report of New Orphan Estimates and a Framework for Action*. New York City: 2004, p. 3.

³ Ibid, p. 10.

⁴ UNAIDS, *Accelerating Action against AIDS in Africa*, p. 24 <http://www.unaids.org>.

⁵ Stanmeyer, Anastasia, "AIDS in Asia: Cruel Epidemic Hits Kids Hard." *San Francisco Gate*, December 19, 2002 <http://www.sfgate.com>.

⁶ The issue of terminology is explored further in "Issues for Congress."

⁷ The most recent report on children orphaned by AIDS, *Children on the Brink 2004*, only offers updated data on children orphaned by AIDS in Africa. There is no updated information on children orphaned by AIDS for the other regions. However, there are new figures for the total number of orphans per region. In Asia, by the end of 2003, there were 87.6 million orphans.

have expressed concern that Asia's relatively large population hides its significant population with HIV/AIDS. For example, although India had a seroprevalence.⁸ rate of less than 1% at the end of 2003, 5.1 million people were living with HIV/AIDS at that time.⁹ This is almost as many people who had the virus in South Africa (5.3 million) at the end of 2003, which had a seroprevalence rate of 21.5%.¹⁰

Children living in high seroprevalence areas may see a decline in access to education or in the quality of education. A 2000 study found that an HIV-infected teacher loses approximately six months of professional working time before succumbing to the virus.¹¹ This has had a significant impact on heavily affected countries such as Kenya, where teachers are dying faster than they can be trained and replaced. Kenya faces the loss of 6,570 teachers annually due to HIV/AIDS, which translates to 18 teacher deaths per day.¹² In the Central African Republic, almost as many teachers died of AIDS as retired between 1996 and 1998. As a result, nearly two-thirds of the schools have closed due to staff shortages.¹³ Heavily affected communities produce lower crop yields due to a reduction in land use (those who are ill with AIDS are often too weak to farm), and a decline in the variety of crops grown. The infrequent use of fertilizers in the fields often results in a decline in soil fertility, increases in pests and diseases, and a decline of external production outputs, including cash crops.¹⁴ As a result, countries significantly impacted by HIV/AIDS have experienced a rise in child mortality and a decline in the gains made in child survival over the past decade. For example, child mortality in Kenya was 205 per 1,000 in 1960, and had fallen to 97 per 1,000 in 1990. However, due to HIV/AIDS the rate increased to 122 per 1,000 in 2001.¹⁵

The majority of children orphaned or made vulnerable by HIV/AIDS are living with a surviving parent, or within their extended family (often a grandparent). An estimated 5% of children affected by HIV/AIDS worldwide have no support and are living on the street or in residential institutions. Although most children live with a caretaker, they face a number of challenges, including finding money for school fees, food, and clothing. Experts contend that effective responses must strengthen the capacity of families and communities to continue providing care, protect the children, and to assist them in meeting their needs. There are thousands of localized efforts, many of them initiated by faith-based groups, to address the needs of children made vulnerable by AIDS. Proponents argue that supporting these "grassroots" efforts can be a highly cost-effective response, although additional mechanisms are needed to channel such resources. They further assert that additional resources are needed to expand the limited programs and to support the children who are on the street or in institutional care.

⁸ Seroprevalence rate means HIV/AIDS rate.

⁹ UNAIDS and WHO, *Epidemiological Fact Sheets: India*. Geneva: 2004, p. 1.

¹⁰ UNAIDS and WHO, *Epidemiological Fact Sheets: South Africa*. Geneva: 2004, p. 1 at http://www.who.int/GlobalAtlas/PDFFactory/HIV/EFS_PDFs/EFS2004_ZA.pdf.

¹¹ Hepburn, Amy E., *Primary Education in Eastern and Southern Africa: Increasing Access for Orphans and Vulnerable Children in AIDS-Affected Areas*, Terry Sanford Institute of Public Policy, Duke University, June 2001, p. 12.

¹² allAfrica.com, "A Lesson from AIDS among Teachers," October 29, 2001 <http://www.allafrica.com>.

¹³ UNAIDS, *Fact Sheets—HIV/AIDS and Development*, at <http://www.unaids.org>; and ILO, *HIV/AIDS in Africa: The Impact on the World of Work*, at <http://www.ilo.org>.

¹⁴ Food and Agriculture Organization of the United Nations (FAO) website, *AIDS and Agriculture in sub-Saharan Africa* (June 1996), at <http://www.fao.org>.

¹⁵ UNICEF, "State of the World's Children 2003," table 1, p. 85, at <http://www.unicef.org>.

Most Recent Developments

The plight of children affected by HIV/AIDS is gaining increased congressional attention, particularly through the enactment of P.L. 108-25, *The United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003*, which authorized 10% of global HIV/AIDS funds to be used for children orphaned or made vulnerable by the virus (OVC). In the 108th Congress, there was considerable debate on how the funds should be allocated. Many pointed out that activities related to children affected by HIV/AIDS should be streamlined. Some wanted to create a coordinator for children orphaned and affected by HIV/AIDS in the AIDS Coordinator's Office of the State Department. Still others argued that the scope of assistance should be expanded to include children who are orphaned from other causes, as they are just as vulnerable as those orphaned by HIV/AIDS. In the 108th session, Congress considered four bills that targeted children orphaned and affected by HIV/AIDS, though none made it to full conference.

In the 109th session, H.R. 1409, Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2005, passed the House and Senate on October 18, 2005 and October 25, 2005, respectively. Ultimately, the bill was enacted on November 8, 2005. The act, P.L. 109-95, authorized spending for orphan-related programs in FY2006 and FY2007; established a monitoring and evaluation system to measure the effectiveness of related assistance activities; directed the appointment of a Special Advisor for Assistance to Orphans and Vulnerable Children within USAID; and required an annual report on project implementation.

Orphans and Other Children Made Vulnerable by HIV/AIDS: Challenges for Governments

The continued increase in international HIV rates is proving devastating for governments heavily affected by HIV/AIDS, not only because their most productive populations are being decimated, but also because the future of these countries and their children is at risk. Governments with significant populations of children orphaned and made vulnerable by HIV/AIDS may be faced with a range of issues, including surging street children populations, a rise in child labor, child prostitution and other forms of exploitative work, vulnerability to crime, militias and terrorist organizations, a growing population of uneducated and unskilled laborers; and long-term foreign aid dependence. This section will explore some of these challenges, and the implications that they have on affected countries.

Street Children and Exploitation

As HIV/AIDS rates continue to soar around the world and household poverty deepens, children are increasingly pressured to contribute financially to the household. The streets have become the place where children orphaned and made vulnerable by HIV/AIDS often turn to supplement lost wages, find refuge, and sometimes to find an escape from stigma. While on the street, children can be exposed to rape, drug abuse, child labor,¹⁶ including child prostitution, and other forms of exploitation, making them more vulnerable to contracting HIV/AIDS. Children as young as nine years old have been found to be engaged in sex work.¹⁷

¹⁶ For more information on international child labor, see CRS Report RL31767, *Eliminating International Child Labor: U.S. and International Initiatives*, by Tiaji Salaam.

¹⁷ Human Rights Watch, *In the Shadow of Death: HIV/AIDS and Children's Rights in Kenya*, June 2001, at

While no one seems to know how many children actually live on the streets worldwide, many reports cite a UNICEF estimate of 100 million.¹⁸ Country reports from a number of heavily affected nations all report a significant increase in the number of children roaming the streets over the past ten years. The city of Blantyre, Malawi, has reportedly seen an 150% increase in the number of children roaming the streets since 2002, with 40 new children coming into the streets each month.¹⁹ Tegucigalpa, the capital of Honduras, has experienced an eightfold increase of street children in the last decade.²⁰ Kenya has become infamous for its exploding population of street children, who are known for committing petty crimes, like stealing cell phones and wallets, mostly because they have no other means of survival.²¹

A number of reports emphasize that the majority of children on the streets have families and homes in which to sleep. However, most children go to the streets for about 12 hours to beg, work, or to seek food, and then return home to sleep. Children as young as two years old have been sent out by their parents to beg for food and money.²² Whether the children live on the streets or spend the majority of their days on the streets, experts are concerned about their vulnerability to terrorist organizations and militias, crime, and HIV infection. A UNICEF worker in Kenya recently asked, “What kind of adults does such an existence produce, if crime and violence become their survival strategies?”²³

Many analysts have expressed concern that the growing number of orphaned children and those on the streets are increasingly rootless, uneducated, undernurtured and traumatized, making them ripe for recruitment for crime, military warlords and terrorists. Children as young as seven years old are among the 300,000 children fighting in wars around the world today. Some are particularly concerned that orphans and other children affected by HIV/AIDS can become easy conscripts for warring factions, as they search for food, shelter, nurturing, and safety. A rebel fighter in Congo reportedly claimed that his militia pays the school fees for the children in his group, most of whom are orphans.²⁴ Children’s vulnerability to other forms of exploitation was illustrated in a study conducted by the International Labor Organization (ILO). The study found that in Zambia the majority of street children and children involved in sex work were orphans. Another study in Ethiopia found that the majority of child domestic workers were orphans. It was found in Uganda that girls were especially vulnerable to sexual abuse while engaged in domestic work.²⁵ Scott Evertz, Director of the White House Office of AIDS Policy has said:

More and more AIDS orphans are growing into young adults with little or no adult supervision. Clearly this presents a security risk. We will have whole populations of them

<http://www.hrw.org/reports/world/kenya-pubs.php>.

¹⁸ *Amnesty International Magazine*, “Amnesty: On the Streets,” Accessed on October 7, 2003, at <http://www.amnesty.org.uk/news/>.

¹⁹ Afrol News, “More Street Children as Malawi Food Crisis Deepens,” February 5, 2003, at <http://www.afrol.com>.

²⁰ Collymore, Yvette, “Migrant Street Children on the Rise in Central America,” Population Reference Bureau, January-March 2002, at <http://www.prb.org/>.

²¹ Wax, Emily, “A Generation Orphaned by AIDS,” *Washington Post*, August 13, 2003.

²² UNICEF, *A Study on Street Children in Zimbabwe*, 2001, at http://www.unicef.org/evaldatabase/index_14411.html.

²³ Jingzhong, Wang, “AIDS Orphan Crisis Poses Grave Challenge to Africa,” *Xinhua General News Service*, November 28, 2002.

²⁴ Wax, Emily, “Boy Soldiers Toting AK-47s Put at Front of Congo’s War,” *Washington Post*, June 14, 2003.

²⁵ Department of State, “AIDS Orphans Crisis Looms, Action Needed, UNICEF Says,” *Washington File*, November 27, 2002, at <http://usinfo.state.gov/>.

in much of the world, ripe for the picking by those individuals who would want to engage the interests of young adolescents. Terrorists would find this an ideal breeding ground.²⁶

Although a number of social scientists have raised concerns about the growing number of children orphaned and made vulnerable by HIV/AIDS, others feel that the prediction of rising crime rates and increased political instability is alarmist.²⁷ Those who dispute the linkage between social breakdown and increased orphanhood cite a lack of evidence and a reliance on anecdotal data. Furthermore, they argue that children have lived among extended family members for some time, particularly in southern Africa, where a significant proportion of the population are migrant laborers. Those that believe the family networks are strong and can support and adapt to the growing number of orphans point to a study conducted in Cape Town, South Africa, which found that before AIDS was a factor, at some point in their childhoods 18% of Africans surveyed were reared in households that were headed by neither their mother nor father.²⁸ The key point that critics underscore is that linking orphanhood to increased crime or insecurity “prematurely labels orphaned children and youth as delinquents and criminals before the necessary contextual research has been carried out.”²⁹ Critics argue that this only furthers the stigma that children orphaned and made vulnerable by HIV/AIDS already face.

Education and the Economic Impacts

Some social scientists are concerned that the growing number of children affected by HIV/AIDS could lead to a decrease of skilled laborers within a country, further destabilizing the national economy and society at large. The issue is that an inefficient transfer of skills and scholarship leads to a decline in human capital, the body of knowledge, and ability found in a population. It is human capital that drives economic growth, some experts argue, and when that is threatened so is the economic security of a nation. A 2003 World Bank report warned that “a widespread epidemic of AIDS will result in a substantial slowing of economic growth, and may even result in economic collapse.”³⁰ The report argues that the effects of these weakened knowledge-transmission processes are felt only over the longer run, as the poor education of children today leads to the low productivity of adults in the future.

In many parts of the developing world, people rely on their own plots of land for the majority of their food consumption and income. However, significant populations of engineers, miners, police, lawyers, and the like rely on skills gained through education and professional training for income. Children who are affected by HIV/AIDS are less likely to be employed in these professions, as they have a lower chance of completing basic and secondary education. Without education and skills training, children orphaned and made vulnerable by HIV/AIDS are more likely to fall deeper into the cycle of poverty and engage in high-risk behavior, which perpetuates the cycle of HIV transmission. Ultimately, the affected countries might find it harder to overcome national poverty and become effective members of the international economy.

²⁶ Gibson, William E., “AIDS Crisis Spurs US into Action,” *South Florida Sun-Sentinel*, June 23, 2002.

²⁷ Bray, Rachel, “Predicting the Social Consequences of Orphanhood in South Africa,” Centre for Social Science Research (CSSR) Working Paper 29, February 2003.

²⁸ Nattrass, Nicoli, “AIDS and Human Security in Southern Africa,” Centre for Social Science Research (CSSR) Working Paper 18, November 2002, p. 9.

²⁹ Bray, Rachel, “Predicting the Social Consequences of Orphanhood in South Africa,” Centre for Social Science Research (CSSR) Working Paper 29, February 2003, p. 9.

³⁰ Bell, Clive, Shanta Devarajan, and Hans Gersbach, “The Long-Run Economic Costs of AIDS: Theory and Application to South Africa” (Washington: World Bank, June 2003), p. 6, at http://econ.worldbank.org/files/30343_wps3152.pdf.

The economic challenges of children affected by HIV/AIDS occur in stages. The first stage often begins when children realize that their parent has AIDS and is likely to die. They begin to fear for their future, wonder who will care for them, and worry about how they will be able to stay in school. Children are often pulled out of school to care for an ailing family member, or because meager household income is now spent on the sick. School fees, notebooks, and pencils become unaffordable and children begin to struggle to provide care and replace lost adult labor and income. At this stage, the quality of child-rearing is compromised, and many important lessons on life skills and self-sufficiency are not taught, mostly because the parent(s) is too ill to transfer the knowledge. After one parent dies, most children continue to live with the surviving parent or a relative, but they often slide more deeply into poverty. For some, the next stage begins when they find themselves the heads of households. A young adolescent may be responsible for many siblings, some of whom may be infants. Children who are the heads of households are in a difficult position not only because they must now support their siblings with little to no education and/or employable skills, but also because they most likely have limited resources. In many cases much of the family's possessions may have been sold to care for the sick. Large numbers of orphaned children find themselves in homes that cannot afford to pay school expenses and drop out to work in the household, fields, or on the street. Young children with minimal education or employable skills can be found doing work such as shining shoes, begging for money in the streets, bartending, selling food, and most often in the case of girls, becoming domestic workers. Many observers believe that the desperation of these young children makes them more vulnerable to abuse and exploitation, ultimately making them more susceptible to contracting HIV.

Agricultural and Food Impacts

Stories of children going hungry or starving in areas that always had food, because HIV-infected parents who were farmers became too weak to till the fields are increasingly reported across Africa. Many traditional agrarian societies rely on women to produce food, particularly in Africa, where 80% of subsistence farmers are women.³¹ During times of famine these women know which wild grains, roots, and berries can be eaten when there are no crops.³² The women also teach their children how to farm and survive off the land. As significant numbers of women of childbearing age fall ill due to HIV/AIDS, they become unable to transfer these skills to their children, both in times of famine and without. This is of particular concern in Africa, where 67% of all people infected with HIV/AIDS are women.³³ Farmers in the last stages of AIDS usually produce little to no crop yields. Lower crop yields within households require the families to spend more of their money on food, leaving less money for education and health care. Additionally, families affected by HIV often switch to a monocrop system or shift from labor-intensive crops, such as vegetables, to less labor-intensive crops, such as roots. Both changes impact nutrition as the family has less access to a variety of nutritious foods because of a decline in productivity and in purchasing power.

The economic impact of HIV/AIDS on Africa's agricultural system is also being felt, particularly in Southern Africa, the region with the highest HIV/AIDS rates and from where much of the continent's food products were exported. According to UNAIDS, the agricultural sector accounts for 24% of Africa's gross domestic product, 40% of its foreign exchange earnings, and 70% of its

³¹ World Economic Forum, "African Food Security: A Role for Public-Private Partnership," December 6, 2003, at <http://www.weforum.org>.

³² De Waal, Alex, "What AIDS Means in Famine," *New York Times*, November 19, 2002.

³³ World Economic Forum, "African Food Security: A Role for Public-Private Partnership," December 6, 2003, at <http://www.weforum.org>.

employment. Experts predict that AIDS will have killed one-fifth or more of agricultural workers in southern Africa by 2020.³⁴ A decline in productive yields is already being seen. In the early 1990s many of the countries in the region exported their surplus grain production, while producing enough food to feed their own populations. In 2002, however, 15 million people faced hunger and starvation in the region, and a number of the countries continue to struggle with hunger.

Some of the countries in the region have become reliant on the World Food Program (WFP) to feed millions of residents. The Southern Africa Development Community (SADC)³⁵ projected a deficit of 3.22 million tons of cereal in FY2002, and ultimately required between 3.6 and 4.6 million tons of cereal to meet the shortfall.³⁶ In 2003, WFP continued to seek support in its effort to feed 6.5 million people facing severe hunger in Zimbabwe, Mozambique, Swaziland, and Malawi.³⁷ The United Nations reported that in 2004, Lesotho, Malawi, Swaziland, and Zimbabwe still required assistance. Half of the population in Lesotho and 25% of all Swazis are at risk of hunger or starvation until the next harvest in March 2005. In Malawi, some 1.7 million people, mainly in the south, need assistance. It is estimated that 4.7 million people desperately need food assistance in Zimbabwe, mostly caused by a reduction in commercial maize production (due to the land redistribution program) and sharp increases in food prices. The World Food Program (WFP) has expressed disappointment by the minimal response to the global appeal for \$404 million for 2002-2005. To date, WFP has only received 2.5% (about US \$10 million) to stave off hunger in southern Africa.³⁸

Household crop supply in the region has been further strained as neighboring families attempt to take in children who have lost their parents to AIDS. The long-term impact is of special concern as an increasing number of children are losing the opportunity to learn how to farm because their parents have died an early death from AIDS. Some experts have expressed concern that in the long-run African people will be unable to sustain themselves as they are forced to put off transferring life skills to cope with HIV/AIDS.³⁹ In recognition of the long-term effects of AIDS on nutrition and food security, WFP has announced that it is now a cosponsor of the Joint United Nations Programme on HIV/AIDS (UNAIDS).⁴⁰ A significant part of its efforts will include integrating food aid with education programs.⁴¹

³⁴ UNAIDS, *2004 Report on the Global AIDS Epidemic: Executive Summary*. Geneva: 2004, p. 10, at <http://www.unaids.org>.

³⁵ SADC comprises the nations of Angola, Botswana, Democratic Republic of Congo (DRC), Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia, and Zimbabwe.

³⁶ "Food Crisis in Southern Africa," *SafAIDS News*, vol. 10, no. 2 (June 2002), p. 10, at <http://www.safaids.org.zw>.

³⁷ "Food Aid Needs in Southern Africa Remain Massive," WFP News Release, November 4, 2003, at <http://www.wfp.org>.

³⁸ UN Office for the Coordination of Humanitarian Affairs (OCHA), *Southern Africa: More than food aid needed for recovery*. February 10, 2005. See <http://www.irinnews.org>.

For additional reading on hunger and HIV/AIDS, also see OCHA, *The Impact of AIDS on Agriculture*. October 22, 2004. See http://www.sahims.net/archive/Briefcases/2004/reg_briefcase_066.htm.

³⁹ de Waal, Alex, "What AIDS Means in a Famine," *New York Times*, November 19, 2002.

⁴⁰ U.S. Department of State, *Washington File*, "World Food Program to Cosponsor U.N. HIV/AIDS Program," October 16, 2003.

⁴¹ This issue is further discussed below in the "Responses to Impact" section.

Stigma, Discrimination, and Depression

According to UNAIDS, stigma and discrimination continue to accompany the HIV/AIDS epidemic. Children are not immune from stigmatization. In cases of stigma, children begin to be rejected early as their parents fall ill with AIDS. Some children may be teased because their parents have AIDS, while others may lose their friends because it is assumed that proximity can spread the virus. Harsh cases of discrimination have been reported in many countries, including India and Trinidad and Tobago, particularly for HIV-infected children. A UNAIDS study found that HIV-related stigma is particularly high in India, where 36% of the respondents in a survey felt that HIV-positive people should kill themselves, and the same percentage felt they deserved their fate. Another 34% reported that they would not associate with an HIV-infected person.⁴² A recent story illustrated how the desire to disassociate from HIV-positive people impacts children. Two HIV-positive children, who lost both of their parents to HIV/AIDS, were repeatedly barred from schools for two years in India. After the children and their grandfather protested in front of government buildings, one school finally accepted them. However, all 100 of their schoolmates were withdrawn by their parents fearing infection by association.⁴³ Ultimately the government decided to pay for a private tutor so that the children could learn at home.⁴⁴ Children were similarly shunned in Trinidad and Tobago when they were refused entry into schools for six months. One school has finally agreed to accept them, but refuses to give their names in order to avoid protests as have happened in the past.⁴⁵

Even children who are not HIV-positive may find themselves rejected and alone. This only adds to the feelings of anger, sadness, and hopelessness that they may feel after witnessing their parents slowly and painfully die. One study in Kenya found that 77% of the children orphaned by AIDS said that they had no one outside of their families to “tell their troubles to.”⁴⁶ The feeling of isolation can be heightened if the orphaned children are separated from their siblings, as often occurs when family members split up the child rearing duties. Another survey conducted in Kenya by the United Nations Development Programme (UNDP) found that 48% of the households with orphans reported that some of their family members were relocated to other communities.⁴⁷ Sibling separation can be difficult for children as they often rely on each other to cope with the loss of their parents.

Children who are orphaned by AIDS often have a lower performance in school than children who are not. The preoccupation with the illness or death of their parents, the isolation due to the loss of friends, and the undertaking of additional work that comes with caring for ill parents or supporting oneself after one’s parents have died often make it difficult for orphaned children to concentrate in school. It is common for teachers to report that they find orphaned children

⁴² Aggleton, Peter, Shalini Bharat, and Paul Tyrer, *India: HIV and AIDS-related Discrimination, Stigmatization and Denial* (Geneva: UNAIDS, 2001), p. 8.

⁴³ Philip, John, “India-AIDS-Schools: Indian School Ostracized after Admitting HIV-Positive Children,” *Agence France-Presse*, March 2, 2003.

⁴⁴ “No School for India AIDS Victims,” *BBC Online*, March 5, 2003, at http://news.bbc.co.uk/2/hi/south_asia/2821347.stm.

⁴⁵ Posted on AIDS Education Global Information System (AEGIS), reported by Richards, Peter, “Rights-Trinidad and Tobago: Children with AIDS Continue to Be Shunned,” *Inter Press Service*, June 3, 1999, <http://www.aegis.com>.

⁴⁶ Human Rights Watch, “In the Shadow of Death: HIV/AIDS and Children’s Rights in Kenya,” *Human Rights Watch Publications*, vol. 13, no. 4(A) (June 2001), p. 17, at <http://www.hrw.org/reports/2001/kenya/>.

⁴⁷ Ayieko, M. A., “From Single Parents to Child-Headed Households: The Case of Children Orphaned by AIDS in Kisumu and Siaya Districts,” UNDP Study Paper 7, 1998, pp. 7 and 14, at <http://www.undp.org/hiv/publications/study/english/sp7e.htm>.

daydreaming, coming to school infrequently, arriving at school unprepared and late, or being non-responsive in the classroom. Some teachers ignorant of the cause of the children's distress, are not sympathetic. Orphaned children have reported that unsympathetic teachers yelled at them, made fun of them, or put them out of the classroom. However, other orphaned children have reported that their teachers have been their primary support base at school.⁴⁸

Orphaned children can also experience discrimination and exploitation within their new households. Reports have emerged of orphaned children receiving less food, denied school fees, and forced to do more work. Exploitation remains an issue even in countries like Botswana, where the government offers support to orphans. It has been reported that some caretakers, while offering minimal care, are using children to benefit from the government orphan packages.⁴⁹ Children, especially girls, have also reported instances of sexual abuse in their new households. However, many may silently accept it because they have nowhere else to turn for shelter or protection.⁵⁰

Gender Exploitation

The rapid spread of HIV/AIDS in many countries is fueled by gender inequities. Since girls tend to be educated at lower rates than boys, some assert they are more likely to engage in survival sex. A UNAIDS survey found that of the estimated 2 million female sex workers in India, 20% were under the age of 15 and nearly 50% were under 18.⁵¹ In addition to the practice of exchanging sex for food, money, and clothing, as discussed earlier, young girls face a range of challenges that affect their seroprevalence. While at school young girls may be raped by their peers or coerced into having sex with their teachers.⁵² Young girls are also vulnerable to sexual exploitation as they work, particularly as vendors and domestic servants. A study in Fiji found that 8 in 10 young domestic workers reported having been sexually abused by their employers.⁵³ Young girls often engage in domestic work for food, clothing and shelter in impoverished areas. Sexual abuse by male relatives also remains a significant challenge for girls, particularly for orphans.⁵⁴ Additionally, a widespread perception that virgins can cure HIV/AIDS has reportedly led to a significant rise in cases of rape among young girls.⁵⁵ One case that shocked the world

⁴⁸ UNAIDS, "Investing Our Future: Psychosocial Support for Children Affected by HIV/AIDS," *UNAIDS Case Study*, July 2001, p. 30, at <http://www.unaids.org/en/default.asp>.

⁴⁹ UN Office for the Coordination of Humanitarian Affairs, "Botswana: AIDS Orphans Exploited," October 8, 2003, <http://www.irinnews.org/AIDSreport.asp?ReportID=1477>.

⁵⁰ *Suffering in Silence: The Links between Human Rights Abuses and HIV Transmission to Girls in Zambia*, a Human Rights Watch report released in November 2002, discusses the sexual vulnerabilities of young girls, at <http://www.hrw.org/reports/2003/zambia/zambia1202.pdf>.

⁵¹ UNAIDS, "Children and Young People in a World of AIDS," <http://www.unaids.org>.

⁵² Human Rights Watch Press Release, "South Africa: Sexual Violence Rampant in Schools," March 27, 2001, at <http://www.hrw.org/press/2001/03/sa-0327.htm#stories>. See also *Scared at School: Sexual Violence Against Girls in South African Schools*, Human Rights Watch Publications, at <http://www.hrw.org/reports/2001/safrica/>.

⁵³ UNICEF, "Gender, Sexual and Reproductive Health—Including HIV/AIDS and Other STIs," in *Gender and Relationships: A Practical Action Kit for Young People*, p. 84, at http://www.unicef.org/lifeskills/genderandrelationships_unit4.pdf.

⁵⁴ For more information on some of the gender-based violence that contributes to the rapid spread of HIV/AIDS, see Human Rights Watch, "Suffering in Silence: The Links between Human Rights Abuses and HIV Transmission to Girls in Zambia." Similar stories can be found in many countries. See, for example, at <http://www.hrw.org/reports/2003/zambia/zambia1202.pdf>.

⁵⁵ Kaiser Family Foundation, "Rise in Child Rapes in Zambia Traced to AIDS Cure Myth, Some Say," December 22, 2003, at <http://www.kaisernetwork.org/>.

occurred in South Africa, where a five-month-old baby was raped by two men hoping to cure themselves of AIDS.⁵⁶

Recent data highlight how girls are particularly vulnerable to contracting HIV. UNICEF conducted a study with UNAIDS and WHO in 2002, and found that “two-thirds of all newly HIV-infected 15-19 year olds in sub-Saharan Africa were female. [Further], in Ethiopia, Malawi, Republic of Tanzania, Zambia and Zimbabwe, for every 15-19 year old boy who is infected, there are five to six girls infected in the same age group.”⁵⁷ Sexual abuse and exploitation are not the only reasons that girls and women have a higher HIV rate than their male counterparts in Africa. The upsurge in the number of girls who turn to older men to pay school expenses, protect themselves from the violence, or to escape poverty also contributes to the gender disparity in seroprevalence rates in sub-Saharan Africa. Unfortunately, this practice places young girls at greater risk of contracting HIV, as the men can often convince the young girls that protection is not necessary. A recent survey found that between 12% and 25% of girls’ partners in sub-Saharan Africa were at least 10 years older, and 25% of Kenyan men over 30 years old reported that their non-marital partners were at least 10 years younger.⁵⁸ There are a number of programs that seek to empower girls and young women, which contribute to HIV/AIDS prevention.⁵⁹

Responses to Impact

Children affected by HIV/AIDS need support in a wide range of areas, including economic, material, emotional, and legal protection. Although a number of organizations seeks to meet the needs of children orphaned and made vulnerable by HIV/AIDS, local communities continue to be the primary loci of support for these children. One USAID survey found that 74% of the time relatives provided food for orphans and vulnerable children, and 19% of the time they relied on their friends for food. Religious groups were used the remainder of the time (7%), when needed.⁶⁰

Economic and Material Responses

This section discusses some of the initiatives that the United States and the international community implement to serve the needs of the children affected by AIDS, and some of the challenges that these programs face.

⁵⁶ Johnston, Jenny, “South Africa’s Secret Horror,” *The Mirror*, February 8, 2003.

⁵⁷ UNAIDS, UNICEF, and WHO, *Young People and HIV/AIDS: Opportunity in Crisis*. 2002, at <http://www.unicef.org/newsline/02pr42opportunity.htm>.

⁵⁸ UN Integrated Regional Information Networks, “The Sugar Daddy Phenomenon,” July 24, 2003, at <http://www.aegis.com/news/irin/2003/ir030735.html>.

⁵⁹ See Hughes-d’Aeth, Armand, “Evaluation of HIV/AIDS Peer Education Projects in Zambia.” *Pergamon: Evaluation and Program Planning* 25 (2002), 397-407, at http://www.unicef.org/evaldatabase/ZAM_98-801.pdf; African Microenterprise AIDS Initiative, “Preventing the Spread of AIDS by Empowering Women in Africa,” at <http://www.microcreditsummit.org/press/Africanmicro.htm>; Ellis, Susan, *Dobriansky Promotes Women’s Empowerment in Botswana*, U.S. Department of State, November 18, 2003, at <http://usinfo.state.gov/regional/af/usafr/a3111701.htm>; USAID, “Angola Female Literacy Center-Horizonte Azul,” at <http://www.usaid.gov/regions/afr/ss02/angola2.html>; “Khmer HIV/AIDS NGO Alliance Offers HIV/AIDS Awareness to Women in Cambodia,” see at <http://www.savingwomenslives.org/pok.htm>; UNICEF, “What Are UNICEF Strategies for Addressing Girls’ Education?,” at http://www.unicef.org/girlseducation/index_strategies.html.

⁶⁰ UNICEF presentation at USAID-sponsored “Orphans and Vulnerable Children: Technical Consultation,” November 3-5, 2003, Washington, D.C., at <http://sara.aed.org/ovc-tc/>.

USAID supports a number of programs that offer material and other support to orphans and vulnerable children, mostly through its Child Survival and Health Fund (CSH) programs. Many of the programs use an integrated approach, which responds to more than one set of needs. For example, USAID uses a combination of funding sources⁶¹ to support school feeding programs that reduce hunger, malnutrition, and disease while advancing basic education.⁶² Similar programs that combine food and education aid have been instituted by the World Food Program (WFP) and UNICEF,⁶³ as well as by other international and local non-governmental organizations, such as Save the Children.

Since the majority of orphans and vulnerable children depend almost exclusively on their families and communities, some are advocating that organizations directly offer support to those groups. Suggested interventions include issuing stipends, financial assistance, or emergency support for families who care for orphans and vulnerable children and those that slip into complete destitution. Critics of this strategy have expressed concern that children can be exploited through direct stipends, such as has reportedly happened in Botswana. Although the country provides stipends, food aid, and pays school fees for its orphaned children, some caretakers are reportedly giving the children substandard care.⁶⁴ Observers assert that empowering community groups to monitor the care and support provided can minimize instances of exploitation.⁶⁵ Additionally, school feeding programs and community cooperatives have been found to be effective strategies to supplement the care that communities provide for vulnerable children, and minimize the likelihood of abuse. Microfinance services are also seen by some as a promising way of enabling families who care for orphans to support themselves.⁶⁶

Education and Skills Training

Attaining basic education and employable skills is an important part of preventing the spread of HIV/AIDS and breaking the cycle of poverty. Education has a number of positive impacts, particularly for orphans and vulnerable children. Not only are those who are educated more likely to have a higher income than those who are not, studies have also shown that the educated are also less likely to contract HIV and tend to have children later in life. Messages about HIV prevention are beginning to be integrated into school curricula to raise awareness about the

⁶¹ School feeding programs can be supported by a combination of programs, including Title II Food for Peace Funds, Child Survival and Health Funds, and basic education funds.

⁶² For more information on USAID programs that seek to address the needs of children affected by HIV/AIDS see *USAID Project Profiles: Children Affected by HIV/AIDS*, at http://www.usaid.gov/our_work/global_health/aids/Publications/docs/cabaprojectprofiles.pdf.

⁶³ For more information on WFP programs that integrate food aid and education see “Widening the ‘Window of Hope’ Using Food Aid to Improve Access to Education for Orphans and Vulnerable Children in sub-Saharan Africa,” at http://www.wfp.org/aboutwfp/downloads/2003/0309_AIDS_Widening_Window.pdf.

⁶⁴ U.N. Office for the Coordination of Humanitarian Affairs, “Botswana: AIDS Orphans Threatened by Exploitation,” October 9, 2002, at <http://www.irinnews.org>.

⁶⁵ A number of national programs encourage community empowerment, such as Farm Orphans Support Trust (FOST), a program in Zimbabwe that aims to increase the capacity of farming communities to respond to the orphan crisis and ensure that systems are in place to protect and care for OVC. See <http://www.cindi.org.za/papers/paper5.htm>. UNICEF also supports a community empowerment program in Swaziland. U.N. Office for the Coordination of Humanitarian Affairs, “Swaziland: Community Provides ‘Shoulder to Cry On’,” December 11, 2003, at <http://www.irinnews.org>. Palmyrah Workers Development Society is a community-based program that seeks to promote HIV/AIDS awareness.

⁶⁶ White, Joanna, *Facing the Challenge: NGO Experiences of Mitigating the Impacts of HIV/AIDS in Sub-Saharan Africa*, University of Greenwich: 2002. This book offers examples of microcredit and other strategies that support community efforts to care for children made vulnerable by HIV/AIDS.

disease among the young, a group that experiences an estimated 1,600 deaths daily.⁶⁷ HIV/AIDS awareness remains very low among the young. According to a 2001 UNAIDS survey, 74% of young women and 62% of young men aged 15-19 in Mozambique are unaware of any way to protect themselves against HIV. Furthermore, half of the teenage girls surveyed in sub-Saharan Africa did not realize that a healthy-looking person could be infected with HIV/AIDS.⁶⁸

Organizations are implementing a variety of approaches to increase access to education among orphans and vulnerable children. Some advocate implementing programs that offer both traditional and non-traditional responses, such as community schools, vocational training, and interactive radio education. Community schools have been an attractive alternative to some because such schools do not have user fees, uniform requirements, or related school expenses. Additionally, they utilize local teachers who often work on a voluntary basis, and are more affordable and accessible to the poorest children because they are able to adapt to community needs (flexible hours and harvest schedule). Some disadvantages of community schools are that they can be of a lower quality than government schools and risk becoming a second tier for the poorest children. Additionally, volunteer teachers may leave the schools if offered a paid position, the quality of education that they offer may be lower than that of paid teachers, and the community schools could be forced to close if donors decide to spend their funds elsewhere, since the schools rely on donors for infrastructure and material support.

Vocational skills training, particularly farming skills training, is critical in areas where parents have died before relaying knowledge of agricultural procedures.⁶⁹ In an effort to combat famine in heavily affected areas, UNICEF has launched a program in Swaziland that offers training in farming to children orphaned by AIDS and affected by famine.⁷⁰ This program is intended to help the children develop a source of income and combat famine that is affecting the region. Experts argue that vocational skills training programs can have additional benefits for girls. It is hoped that those who participate in vocational training will no longer be forced to rely on sex work to feed themselves and their siblings.⁷¹

Protection and Legal Support

Children who are solely responsible for their siblings struggle not only to support the household, but also to keep their homes. Property grabbing, a practice where relatives of the deceased come and claim the land and other property, is reportedly a serious problem for widows and child-headed households. Traditional law in many rural areas dictates that women and children cannot inherit property. Property grabbing has a number of negative consequences particularly for girls and women. Girls may experience sexual abuse and exploitation from their new caretakers; girls and women may be forced into the sex trade in exchange for shelter and protection, further

⁶⁷ Article found on Factiva website, citing Nyasato, Robert and Samuel Otieno, "HIV/AIDS: Over 1,600 Minors Die Daily," *Africa News Service*, May 13, 2002.

⁶⁸ UNAIDS, "Children and Young People in a World of AIDS," August 1, 2001, at <http://www.unaids.org>.

⁶⁹ For examples of programs that involve youth and support microenterprise efforts, see Horizons, "Microfinance and Households Coping with HIV/AIDS in Zimbabwe: An Exploratory Study," June 2002, <http://www.popcouncil.org/horizons>; Horizons, "Involving Youth in the Care and Support of People Affected by HIV and AIDS," July 2003, at <http://www.popcouncil.org/pdfs/horizons/zmbcsythfnl.pdf>.

⁷⁰ UN Integrated Regional Information Networks, "Swaziland HIV/AIDS Orphans Taught to Farm," July 29, 2003, at <http://www.irinnews.org>.

⁷¹ Chase, Marilyn, "Saying No to 'Sugar Daddies'", *Wall Street Journal*, p. B1, February 25, 2004.

increasing the risk of contracting HIV. Some are concerned that the practice of property grabbing heightens the strain on extended families and increase the number of street children.

In an effort to help parents prevent property grabbing, USAID supports organizations, such as the Population Council and UNICEF,⁷² which work with HIV-infected parents to plan for the future of their children through will-writing and other succession-planning initiatives. These initiatives encourage HIV-infected parents to disclose their HIV status to their children, appoint and train stand-by guardians, create memory books (journals of lasting record of life together and family information), and write wills before they die.⁷³

National legislation, at times, has minimized the effectiveness of succession programs. The legislative issues that AIDS-affected countries are beginning to face are often complex and interlinked. For example, the single issue of inheritance rights may require governments to ensure that each child has a birth certificate and national identification (which many children in developing countries do not have), to strengthen the coordination and administration of their child services and social services departments that offer safety nets to children, to revisit property and trustee laws, and to reconsider who may legally represent minors. Laws in many rural countries follow traditional cultural practices, which are based on the extended family structure. However, in the wake of the HIV/AIDS pandemic, they inadequately protect orphans and widows, as all adults in whole families may have died. When the close family members die, children can be left in a precarious situation, as they may be forced to rely on distant relatives, who may be unknown. In many cases children are left with their grandmothers, women who often have little legal power.

UNAIDS recently reported that 39% of countries with generalized HIV epidemics (countries with an HIV rate of more than 1%) have no national policy in place to provide care and support for orphans and vulnerable children, and 25% have no plans to develop such strategies.⁷⁴ National legislation that would establish and/or enforce inheritance rights of child- and widow-headed households could help to curb the escalating street children population and minimize the practice among young girls and women of trading sex for security and shelter, ultimately contributing to HIV prevention.⁷⁵

The proliferation of property-grabbing has led some to call for an increase in orphanages. Supporters of increasing the use of orphanages argue that many communities are overwhelmed and can no longer effectively care for children orphaned by AIDS. Children who live in orphanages have access to education, food, shelter, and nurturing, which they may not be able to secure on their own, advocates of orphanages say. Some, including USAID, argue that orphanages do have their place in society, but that they should be used only in cases of last resort. Those who express caution about increasing the use of orphanages to respond to the growing orphan population argue that poverty will be the primary reason that parents place their children in institutions. Due to the high level of poverty in many areas, many parents send their children to

⁷² To learn more about Population Council and UNICEF HIV/AIDS programs, see <http://www.popcouncil.org/hiv/aids/index.html> and <http://www.unicef.org/aids/index.html>.

⁷³ Horizons, "Succession Planning in Uganda: Early Outreach for AIDS-Affected Children and Their Families," at <http://www.popcouncil.org/pdfs/horizons/orphanssum.pdf>.

⁷⁴ UNAIDS, "Progress Report on the Global Response to the HIV/AIDS Epidemic, 2003," at http://www.unaids.org/html/pub/Topics/UNGASS2003/UNGASS_Report_2003_en.pdf.htm.

⁷⁵ See Human Rights Watch, "Double Standards: Women's Property Rights Violations in Kenya," March 2003, at <http://www.hrw.org/reports/2003/kenya0303/kenya0303.pdf>.

orphanages simply because they are unable to support them. Research has shown that only 25% of children in institutional care do not have any known relatives.⁷⁶

Supporters of community-based care argue that children who are raised in orphanages have a hard time being self-sufficient as adults because they do not learn life skills, do not have community connections (a critical part of networking and job-seeking), have difficulty adapting to life outside the orphanages, and develop a mentality that they will always be cared for. Ethiopia is currently implementing a country-wide reintegration program, after finding that orphanages were too costly and unhealthy for the social and cultural development of the children.⁷⁷ Some caution that orphanages can undermine community efforts to support orphaned children and separate them from their families. Instead, they argue, efforts to support orphaned children should focus on strengthening community networks and initiatives. In this view, community-based support can both enable the children to stay within their communities, and enable donors to support more children, as the cost of supporting a child in an orphanage is substantially more than supporting a child within its own community.⁷⁸

Psychosocial Interventions

The psychological impact of HIV/AIDS on children is often overlooked. Not only do many children who live in heavily affected areas contend with the death of one or both parents, but they also frequently face the death of younger siblings, aunts, uncles and other relatives. While there are a number of programs that address the material needs of orphans and vulnerable children, there is less emphasis on helping children cope with the trauma associated with witnessing the deaths of family members. The additional burden of caring for terminally ill relatives may send children into shock leaving many of them with unanswered questions about their own mortality and future.

The psychological impact of HIV/AIDS on the young is often misunderstood, particularly in the classroom. Children who are affected by HIV/AIDS may be frequently absent or tardy from school, find it hard to concentrate or unable to assume school-related expenses, such as school fees, uniforms, books and other school supplies. While teachers may have noticed that AIDS-affected children tend to have lower performance in school, many apparently do not link the behavior with HIV/AIDS. As a result, some organizations are beginning to train teachers on how to identify grief-related behavior. Teachers who have completed grief-identification training have reported that the sessions “opened their eyes to the reasoning behind what they had identified as misbehavior of orphaned students.”⁷⁹

⁷⁶ “Report on Meeting on African Children without Family Care,” Windhoek, Namibia, November 30, 2002.

⁷⁷ For more on Ethiopia’s reintegration program, see Jerusalem Association of Children’s Home (JACH), http://www.crdaethiopia.org/CRDA%20News/Special%20Issue/Page_4.htm.

⁷⁸ For more information on the orphanages debate, see Desmond, Chris, and Tim Quinlin, “Costs of Care and Support,” in *Literature Review: The Economic Impact of HIV/AIDS on South Africa* (University of Natal: Health Economics and HIV/AIDS Research Division [HEARD]), 2002, p. 35; Save the Children, “A Last Resort: The Growing Concern about Children in Residential Care,” http://www.savethechildren.org/health/hiv_aids/images/last_res.pdf; Lacey, Marc, “For Children Left Behind, a Place to Feel at Home,” *New York Times*, November 18, 2002; *AIDS Orphans and Vulnerable Children in Africa: Identifying the Best Practices for Care, Treatment and Prevention*, Hearing before the Committee on International Relations House of Representatives, 107th Cong., Second sess., April 17, 2002, Serial 107-84, at http://www.house.gov/international_relations/107/78801.pdf.

⁷⁹ UNAIDS, “Investing in Our Future: Psychosocial Support for Children Affected by HIV/AIDS,” UNAIDS Case Study, July 2001, at <http://www.unaids.org>.

Programs are also being developed that enable children to play, a luxury to many orphans and vulnerable children. Children affected by HIV/AIDS often begin to assume adult responsibilities, such as earning wages, caring for the terminally ill, and cultivating the land, leaving them with little to no time for recreational activities. These children may also be stigmatized and isolated, as ignorance about the virus remains high. There are programs that offer Psychosocial support for orphans and vulnerable children, including peer support groups, recreational activities, and counseling.⁸⁰

While psychosocial support for orphans and vulnerable children is important, the same type of support is often overlooked for caretakers. Reports of grandmothers caring for a dozen children with little to no income are not uncommon. The grandmothers are often exhausted and overworked. In many rural areas, senior citizens have no social security or retirement benefits. As a result, children under their care are more likely to be uneducated and malnourished. In response, caretakers and a variety of organizations have begun to develop programs that offer support to the caretakers. Grandmothers are beginning to form groups where they rotate supervision of children and allow each other an hour of respite. Some are also developing support groups to discuss and find solutions to their problems. Some non-governmental organizations offer stipends and financial support to the caretakers and are training them to talk to the children about their grief.⁸¹

Issues for Congress

Most often when governments of industrialized countries consider strategies to address the needs of children affected by HIV/AIDS, they begin by examining their foreign aid programs. While foreign assistance programs are an important part of the effort, there are a wide range of other issues that are often overlooked. This section discusses a range of issues that impact efforts to help children affected by HIV/AIDS, including how “AIDS orphans” are defined, how U.S. foreign aid programs are implemented, and other related international initiatives.

Targeting Assistance

Due to the high level of stigma still associated with HIV/AIDS, many who work in the development community avoid using the term “AIDS orphans.” The term, some argue, only serves to further stigmatize and separate the children from the others in the community. Those who offer support to communities affected by HIV/AIDS have found that the early programs, which focused specifically on children whose parents died of AIDS, often missed other vulnerable children, such as those who are at high risk of becoming orphaned by AIDS (because their parents have HIV), those who live in households with children orphaned by AIDS, and those who may have been orphaned from other causes (like war or disease) are equally vulnerable. Additionally, in many communities it is often not known who has HIV/AIDS and who does not, due to struggling health care infrastructures and minimal HIV/AIDS testing. As a result, many of the assistance networks, including UNICEF, UNAIDS, and USAID, develop programs that serve

⁸⁰ The Salvation Army has a number of programs which support OVC, one Masiye camp offers skills training, psychosocial support and recreational activities for OVC. See http://www1.salvationarmy.org/www_zim.nsf?OpenTsungirirai offers a range of programs for OVC, including psychosocial support. See <http://www.usafriends.org/about.html>. For more information on USAID psychosocial programs for OVC, see http://www.usaid.gov/our_work/global_health/aids/TechAreas/ChildrenAffected/cabafactsheet.html.

⁸¹ HelpAge International serves to support disadvantaged older people worldwide. For information on its programs that support elderly HIV/AIDS caretakers, see <http://www.helpage.org/images/pdfs/HIVAIDS/ForgottenFamiliesReport.pdf>. Hope Worldwide offers support for adults and children, including support for caretakers to avoid burnout; see <http://www.africa.hopeworldwide.org/world/africa/sections/programs/siyawela.htm>.

the needs of the most vulnerable children in areas seriously affected by HIV/AIDS, many of whom are children orphaned by AIDS.

USAID's approach to assisting children orphaned and made vulnerable by HIV/AIDS has posed a challenge for the U.S. Congress. USAID prefers not to create programs that exclusively serve children orphaned by HIV/AIDS. Representatives have stated that this approach would only serve to further isolate and stigmatize the children. As a result, the Agency supports the children through a number of interventions, which serve their needs, including educational support, school feeding, and psychosocial support. Although this approach is one that is generally accepted among international aid workers, it complicates Congressional efforts to monitor spending per program. P.L. 108-25 required that 10% of international HIV/AIDS funds be reserved for children orphaned and made vulnerable by HIV/AIDS. P.L. 108-199, the FY2004 Consolidated Appropriations, supported the language. Neither USAID nor the Office of the Global AIDS Coordinator has been able to detail exactly how much was spent on each program, such as school feeding, in large part because organizations implementing programs (including USAID-supported programs) use an integrated approach. The programs respond to the needs of the most vulnerable children where they work, rather than only assisting those whose parents have received an HIV/AIDS diagnosis. USAID officials underscore that this approach is also important, as many people in the most affected countries die without an HIV/AIDS diagnosis. Therefore, if it were to restrict services to those children whose parents have officially died of AIDS, it might not meet its fiscal targets. Finally, USAID reports that it often combines funds from different accounts to address the sundry needs of orphans and vulnerable children, including Child Survival and Health Fund, (CSH), HIV/AIDS funds for orphans and vulnerable children, Title II Food for Peace funds, and basic education funds.

Foreign Assistance

Education and Poverty Programs

While funding for HIV/AIDS initiatives has dramatically increased in recent years, U.S. and international funding for other health programs, education and poverty-related programs have remained level and decreased in some cases. Critics argue that this minimizes the effectiveness of HIV/AIDS programs, as many of the issues are interrelated. During a congressional hearing on the U.S. foreign operations appropriations, USAID Administrator Andrew Natsios expressed concern that other programs such as agriculture, which are vital in countering poverty and supporting health programs, are being decreased.⁸² UNICEF estimates that over the past decade international education aid has fallen by 30%. As a result, 65 million girls and 56 million boys did not attend school in 2002. The highest concentration of uneducated children resides in Africa, also home of the highest number of children orphaned by HIV/AIDS. In 2002, the number of African children unable to attend school reportedly rose to 45 million, up from 1990 levels of 41 million.⁸³

Collaboration

Although there are many programs that address the various needs of orphans, as illustrated in this report, some argue that there is not enough collaboration among aid organizations on the ground. Some programs exclusively address the material needs of orphans, while others focus on their

⁸² For further discussion on U.S. health programs funding trends, see CRS Report RL31433, *U.S. Global Health Priorities: USAID's Global Health FY2003 Budget*, by Tiaji Salaam.

⁸³ Donnelly, John, "Funding Lack Keeps Millions Out of School, UNICEF Says," *Boston Globe*, December 12, 2003.

psychosocial needs, still others focus on empowering women and girls. Advocates argue programs could be more effective if there were greater collaboration in their planning and implementation. USAID recognizes that the needs of orphans and vulnerable children are complex. In response, USAID integrates various aspects of its development programs to meet the needs of these children, rather than implement a single program exclusively for them.

There has been an increasing amount of collaboration on the international level with USAID, UNICEF, UNAIDS, WHO, and the other international organizations that address the needs of orphans and vulnerable children. For example, the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS developed a Declaration of Commitment on HIV/AIDS, to which the U.S. is a signatory.⁸⁴ Part of this commitment is that national policies would be developed by 2003 and implemented by 2005, to build and strengthen government, community and family capacity to support children affected by HIV/AIDS. At the regional level, there have been a number of meetings in Africa that brought delegations together to agree on a common set of actions and to measure progress towards them and the UNGASS goals. Additionally, in October 2003, a number of international NGOs, faith-based institutions, governments, and other organizations met and agreed on a global strategic framework for the protection, care and support of orphans and other children made vulnerable by HIV/AIDS at the first Global Partners Forum for Children Orphaned and Made Vulnerable by HIV/AIDS. This is a first step towards improving program effectiveness. However, collaboration efforts at the national and local level are often minimal or non-existent, critics say. As stated earlier, most of the needs of orphans and vulnerable children are met by their communities. Some argue that non-governmental organizations (NGOs) that operate at the local level need greater support and must be included in planning and implementation efforts. Additionally, including local and national NGOs may promote ownership and strengthens local capacity.

Advocates for children affected by HIV/AIDS point out that efforts to respond to their needs are not commensurate to the scale of the problem. A number of options has been put forward to increase the resources for AIDS-affected children. Some observe advocate establishing a Czar for orphans and vulnerable children to oversee U.S. efforts and to galvanize the global effort. Other analysts propose creating a senior orphan and vulnerable children position within the AIDS Coordinator Office. Still some say that the programs that address the needs of children should be strengthened and better coordinated. Proponents of this position emphasize the importance of integrating the care, support, and treatment of HIV-infected children into HIV/AIDS treatment programs and those that prevent mother-to-child HIV-transmission.

The Global Fund to Fight AIDS, Tuberculosis, and Malaria

The magnitude of the HIV/AIDS crisis in seriously affected countries is far too large, varied, and interrelated for any single body to address unilaterally and adequately. Those who believe that a productive response to this crisis requires greater cooperation point to the Global Fund as a model.⁸⁵ The Global Fund has at all levels representatives from the public and private sectors. At the planning level, its board of directors is comprised of seven representatives from donor and developing countries, and a representative each from an industrialized country NGO, a developing country NGO, the private sector, and a contributing foundation. In the project design phase, the Country Coordinating Mechanism (CCM) or “national consensus group” develops project proposals. The CCMs in each country include representatives from the government, NGO

⁸⁴ UNGASS Declaration on HIV/AIDS can be downloaded from <http://www.unaids.org>.

⁸⁵ The Global Fund is a funding entity that partners governments, civil society, the private sector, and affected communities to fight three of the world’s most devastating diseases: HIV/AIDS, tuberculosis, and malaria.

community, private sector, people living with HIV/AIDS, tuberculosis and/or malaria, religious and faith-based groups, academics, and the United Nations agencies. The practice of including all stakeholders in the planning and implementation of projects increases their effectiveness and minimizes the likelihood of duplicating efforts, some claim.

The Global Fund was unable to spend \$87.8 million of the U.S. contribution in FY2004, as it did not receive sufficient matching funds. P.L. 108-25 required that U.S. contributions for fiscal years 2004 through 2008 not exceed 33% of contributions from all sources.⁸⁶ The FY2005 Consolidated Appropriations provided \$437.8 million to the Global Fund, including the \$87.8 million. The funds remain subject to the same 33% limitation. The total U.S. contribution through the end of FY2005 has totaled more than \$1.5 billion. Congress has consistently provided more than the Administration requested. The 33% requirement has caused a number of criticisms. Some believe that the United States should give more money to the Fund, as it has the structure and capability to use the money quickly. Some supporters of this idea also believe that the 33% requirement hinders the ability of the United States to give more. This policy, advocates claim, causes other nations who believe the United States has yet to give its fair share to hold back additional contributions. Critics of this view point believe that the fiscal requirement encourages others to give more to the Fund. Proponents argue that the United States is already the largest donor to the Fund, and should not be the primary contributor. Furthermore some opponents of increasing U.S. contributions to the Fund have questioned the absorptive capacity of the Global Fund, stating that it is spending the money too slowly.⁸⁷ By December 2004, the Fund had only disbursed \$860 million of the \$3.3 billion paid.⁸⁸

Anti-Retroviral Medication

Advocates argue that if the most affected countries had greater access to anti-retroviral (ARV) medication there would be a decrease in the number of new orphans and other vulnerable children. Due to the cost and other factors, only 12% of the 5.8 million people immediately needing AIDS treatment in developing countries have access to treatment.⁸⁹ According to WHO, only 325,000 of those with access to treatment in developing countries (700,000) live in sub-Saharan Africa, where 25.4 million people are currently living with the virus.⁹⁰

Preventing mother-to-child HIV transmission (PMTCT) is a critical part to reducing the growing number of orphans and vulnerable children (OVC) in developing countries, particularly for countries with high seroprevalence rates among pregnant women, including Swaziland (39%), Botswana (32%), South Africa (24%), Kenya (22%), Namibia (18%), Zimbabwe (18%), and Malawi (18%).⁹¹ Access to nevirapine, a relatively inexpensive single-dose drug that significantly reduces the HIV transmission rate from mother to child, is virtually non-existent in many developing countries. In 2003, only an estimated 5% of pregnant women in Africa had access to drugs to prevent mother-to-child HIV transmission, and only 8% globally were offered

⁸⁶ P.L. 108-25, United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, as amended, Section 202.

⁸⁷ For more on the Global Fund, see <http://www.theglobalfund.org>, and CRS Report RL31712, *The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Background and Current Issues*, by Raymond W. Copson and Tiaji Salaam.

⁸⁸ WHO, '3x5' Progress Report, December 2004, p. 26. See <http://www.who.int>.

⁸⁹ Ibid, p. 49.

⁹⁰ Ibid.

⁹¹ Figures in this paragraph were taken from the Joint United Nations Programme on HIV/AIDS (UNAIDS), *Progress Report on the Global Response to the HIV/AIDS Epidemic, 2003*; and UNAIDS, *A Joint Response to HIV/AIDS, 2003*, at <http://www.unaids.org>.

treatment.⁹² It has been estimated that 1,900 children are born with HIV every day in Africa alone.⁹³

Botswana, the first country in sub-Saharan Africa to develop a national anti-retroviral distribution program, is the only developing country where nevirapine is readily available. Although it has a national distribution plan, there are barriers to widespread use of nevirapine and ARVs, including stigma and capacity challenges. At the end of 2002, 34% of pregnant women had access to nevirapine in Botswana and 10,000 people were using ARVs.⁹⁴ The capacity challenges remain a significant challenge for countries that face the HIV/AIDS epidemic, as many of them, including Botswana have considerable shortages of health care workers. The President of Botswana, Festus Mogae, recently discussed this issue when he noted that Botswana struggles with “brain drain,” as skilled health care professionals leave the government or country for more lucrative salaries.⁹⁵

Botswana’s slow ARV distribution has strengthened critics arguments that widespread ARV distribution is not only hindered by high costs, but also by resource constraints. Some have stated that health care infrastructures must first be strengthened before ARV distribution could be more rapidly scaled up. One area that has gained increasing attention is the shortage of trained African health care workers to offer ARV treatments. A UNAIDS report recently cited studies, which estimated that between 19% and 53% of all government health employee deaths were caused by AIDS.⁹⁶

South Africa, a country that formerly rejected the widespread use of nevirapine or other ARV medication, became the second country in sub-Saharan Africa to develop a national anti-retroviral program. It announced in August 2003 that its health ministry would begin a national distribution program. Though the country already offered nevirapine in some areas to pregnant women and emergency AIDS medication to rape survivors, the country leadership came under heavy criticism for not developing an effective national ARV distribution plan. The announced plan sought to establish a service point in each district within one year, and to make anti-retroviral medication available to all South Africans and permanent residents at the municipal level within five years.⁹⁷

Uganda became the third country in sub-Saharan Africa to develop a national anti-retroviral program. It announced in December 2003 that its health ministry in partnership with USAID would launch a three-year program to provide anti-retroviral medication throughout the country. Though Uganda has been hailed as an example of success for effectively bringing down its national seroprevalence rate, there are still more than 500,000 people living with HIV/AIDS in the country,⁹⁸ and nearly one million (940,000) children orphaned due to HIV/AIDS.⁹⁹

⁹² WHO, ‘3x5’ *Progress Report*, December 2004, p. 32, at <http://www.who.int>.

⁹³ Dabis, François, and Ehounou René Ekpini, “HIV/AIDS and Maternal and Child Health in Africa,” *The Lancet*, vol. 359 (June 15, 2002), p. 2097, at <http://www.thelancet.com>.

⁹⁴ Kaiser Family Foundation, “Financial Times Weekend Magazine Examines Botswana’s Antiretroviral Drug Program,” October 14, 2003, at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=1&DR_ID=20321.

⁹⁵ Kaiser Family Foundation, “Botswana Losing Skilled Workers for HIV/AIDS Programs to Non-governmental Groups, President Mogae Says,” November 13, 2003, at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=1&DR_ID=20838.

⁹⁶ UNAIDS, *2004 Report on the Global AIDS Epidemic: Executive Summary*. Geneva: 2004, p. 10, at <http://www.unaids.org>.

⁹⁷ For the text of South Africa’s national ARV plan, see <http://www.info.gov.za/>.

⁹⁸ U.N. Office for the Coordination of Humanitarian Affairs, “Uganda: Programme launched to boost ARV treatment capacity,” December 29, 2003, at <http://www.irinnews.org>.

⁹⁹ UNAIDS, UNICEF, USAID Joint Report, *Children on the Brink 2002: A Joint Report on Orphan Estimates and*

The U.S. government has expanded its HIV/AIDS programs to include care and treatment to people living with HIV/AIDS when Congress passed P.L. 108-25, the “U.S. Leadership against HIV/AIDS, Tuberculosis and Malaria Act of 2003.” The law authorized the U.S. government to offer ARV to at least 500,000 individuals by the end of 2004, and up to 2,000,000 by the end of 2006. Some have criticized the U.S. government, as observers complain that it is moving too slowly to implement the treatment programs. The Office of the Global AIDS Coordinator reports that by September 2004, the President’s Emergency Plan had supported ARV for 155,000 people.¹⁰⁰ Analysts note that if the Administration would work more closely with existing programs, greater results would be achieved.

Congress has already moved to increase access to treatment in the 109th session. H.R. 155, *Mother-to-Child Transmission Plus Appropriations Act for Fiscal Year 2005*, introduced January 4, 2005, seeks to offer additional funding for MTCT-plus programs. Implemented through the Columbia University Mailman School of Public Health, this program provides treatment to the entire family, as opposed to only the child and/or mother. H.R. 155 appropriates \$75 million for this effort in FY2005.

Access to ARVs for Children

Child advocates are calling for more children to receive anti-retroviral therapy. UNAIDS estimates that only between 15,000 and 20,000 children living with HIV/AIDS have access to treatment. The organization believes that 660,000 of the 2 million children living with the virus need immediate care. Until 1990, no antiretroviral (ARV) drug was specifically tested or approved for pediatric use. Only three ARVs are labeled for children under two, come in liquid form, and have WHO-approved generic versions available. The pediatric ARV drugs that are available are significantly more expensive than adult versions—branded pediatric ARV drug formulations cost between 50% and 90% more than adult versions.¹⁰¹

It is particularly challenging to treat infants and young children, as they are unable to swallow pills. This requires that they receive the drugs in liquid form, which has more stringent handling and storage guidelines. Additionally, drug doses are based on children’s changing weights and must be recalculated based on current weight or body surface area and then converted to the appropriate volume based on the formulation strength. This process requires greater human resources, the recalculation of dosages at each visit, and fully-trained doctors. Liquid treatments are not available in all ARVs, and the transition period from liquid to solid pills vary among medications. When liquid treatments are unavailable, providers would need to break adult tablets for lower doses or crush pills into food or fluid. Proper dosage is hard to ensure using these methods. The current shortage of health care practitioners in many developing countries, particularly in sub-Saharan Africa, has posed considerable challenges in treatment efforts among adults. The more complex demands and challenges of treating children has presented additional issues for affected countries.

Insufficient supplies of HIV testing kits are also a considerable problem in many of the most affected countries. For example, in 2004, 35% of HIV-positive babies in Nairobi, Kenya, died by their second birthday. The country had two specialized machines for detecting HIV in the country.

Program Strategies, November 2002, at <http://www.unaids.org>.

¹⁰⁰ U.S. Department of State, *The President’s Emergency Plan for AIDS Relief: Compassionate Action Provides Hope Through Treatment Success*. January 26, 2005. Office of Global AIDS Coordinator website <http://www.state.gov/s/gac>.

¹⁰¹ “Ensuring Access to ARVs for Kids: A Challenge of Logistics.” *Global Health Council*. See <http://www.globalhealth.org/reports/report.php3?id=205/>

Pediatric diagnostic equipment costs around \$40,000 per unit in Kenya, while the cost of testing a child is about \$55. In its 2004 Global Report, UNAIDS said 90,000 infants were exposed to HIV by birth and breast-feeding every year, at least 46,000 of them were infected and 60% died before their second birthday.¹⁰²

Other Tools

Debt Relief

Some argue that the huge debt burden of developing countries, particularly those severely affected by HIV/AIDS, hinders their ability to develop an effective response to HIV/AIDS. Proponents of heavier debt relief argue that many countries, including those receiving debt relief, spend more money on debt payments than on social services. This money, they argue, could be used on other programs that are effective in combating the virus, such as supporting education and health infrastructures.¹⁰³ Oxfam estimates that of the 26 countries participating in the Highly Indebted Poor Countries (HIPC) Initiative, half are still spending 15% or more of government revenues on debt repayments. For example, Zambia is spending 30% more on debt repayment than on health.¹⁰⁴ Furthermore, HIV/AIDS is sinking these countries deeper into poverty, making the debt repayments increasingly harder to pay.

There had been some congressional action on this issue in the 107th and 108th Congresses. H.R. 1567, “Debt Cancellation for HIV/AIDS Response Act” in the 107th Congress, and in the 108th Congress H.R. 643, “To Urge Reforms of the Enhanced Highly Indebted Poor Countries (HIPC) Initiative,” and H.R. 1376, “To Improve the HIPC Initiative” were introduced. All three bills sought to expand debt relief efforts to countries heavily affected by HIV/AIDS. Similar legislation is expected to be introduced in the 109th session. Some are concerned that debt reduction initiatives can be abused, and corruption will undermine debt reduction strategies. Furthermore, it has been argued that it is not debt repayments that are sinking these countries deeper into poverty but the lack of strong revenue sources. If some of these countries would revise their economic and social policies there would be less of a need for debt relief, critics say. In an effort to limit the corruption and careless use of debt relief, international institutions, such as the World Bank and UNAIDS, are working with countries to develop effective, transparent plans to incorporate HIV/AIDS efforts into debt reduction strategies.¹⁰⁵

Agricultural Subsidies

Countries heavily affected by HIV/AIDS need increased revenue to support crumbling health and education infrastructures, offer HIV/AIDS treatment, and develop comprehensive HIV/AIDS

¹⁰² U.N. Office for the Coordination of Humanitarian Affairs, “Kenya: Babies suffer lack of pediatric testing kits.” October 26, 2005. See <http://www.plusnews.org>.

¹⁰³ Clark, Marie, “Debt Relief Will Spur AIDS Plans,” *Philadelphia Inquirer*, May 30, 2003.

¹⁰⁴ *Debt Relief and the HIV/AIDS Crisis in Africa: Does the Heavily Indebted Poor Countries (HIPC) Initiative Go Far Enough?*, Oxfam Briefing Paper 25, at http://www.oxfam.org/eng/pdfs/pp0206_no25_debt_relief_and_the_HIV_crisis.pdf.

¹⁰⁵ UNAIDS, “AIDS, Poverty Reduction, and Debt Relief”. 2001, <http://www.unaids.org/en/in+focus/topic+areas/debt+relief.asp>; World Bank, “AIDS, Poverty Reduction, and Debt Relief,” 2001, at http://www.worldbank.org/afr/hd/wps/poverty_reduction.pdf.

programs. For example, UNICEF recently reported that Kenya would need \$70 million per year to support 1.2 million Kenyan children affected by HIV/AIDS.¹⁰⁶

Some argue that agricultural subsidies hinder the economic growth of countries like Kenya that are affected by HIV/AIDS, and consequently their ability to combat the epidemic. It is estimated that in 70% of developing countries agriculture is the main source of revenue for families, as well as the national economy.¹⁰⁷ However, some have said that agricultural subsidies prevent farmers in agriculture-based economies from exporting their products to global markets, because their unsubsidized prices are higher than the below-market prices of subsidized agricultural goods. The World Bank recently reported that agricultural subsidies in industrialized countries total \$311 billion a year, with sugar subsidies that are nearly equivalent to all exports from all developing nations at \$6.4 billion.¹⁰⁸ The Bank estimated that if agricultural subsidies were eliminated, agricultural and food exports from low and middle-income countries could rise by 24%, increasing rural income by about \$60 billion.¹⁰⁹ Some use the World Bank report to argue that agricultural subsidies also undermine foreign aid efforts. The report estimates that agricultural subsidies are about six times the amount of all foreign aid¹¹⁰ with U.S. subsidies to cotton growers totaling \$3.9 billion in 2003, three times the amount of U.S. foreign aid to Africa.¹¹¹ Concurrently, critics of agricultural subsidies are concerned that the subsidies also increase reliance on foreign aid, because subsidies encourage surplus production of agricultural goods that are ultimately exported to poorer countries who are unable to produce domestic goods at a competitive price. They assert that, consequently, people living in agriculture-based economies have less income to purchase basic necessities, including food, heightening reliance on foreign aid.¹¹²

In an effort to address agricultural trade issues, members of the World Trade Organization (WTO) agreed in Doha, Qatar, in 2001, to lower tariffs and other barriers to free and fair agricultural trade. The WTO Ministerial Conference in Cancún, Mexico, was to follow-up the agreement and develop concrete plans to revise the trade laws.¹¹³ However, talks collapsed when developing countries and industrialized nations could not agree on several issues. Since no progress was made, agricultural tariffs and subsidies remain. The United States maintains that it will continue

¹⁰⁶ Kaiser Family Foundation, "Kenya Needs \$70M Annually to Assist Children Affected by HIV/AIDS, UNICEF Says," July 2, 2003, at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=1&DR_ID=18590.

¹⁰⁷ National Center for Policy Analysis, "Phasing Out Agricultural Subsidies," *Daily Policy Digest*, September 29, 2003, at <http://www.ncpa.org/iss/bud/2003/pd092903c.html>.

¹⁰⁸ Berhelsen, John, "Asia's Take on Cancun," *Asia Times*, September 13, 2003. See http://www.atimes.com/atimes/Global_Economy/EI13Dj01.html.

¹⁰⁹ World Bank, "Cutting Agricultural Subsidies: World Bank Chief Economist Urges Cuts in Rich Country Agricultural Subsidies," November 20, 2002, at <http://www.worldbank.org>.

¹¹⁰ Nicholas Stern, Senior Vice President of the World Bank, first reported the findings at the Munich Lectures on Economics at the Center for Economic Studies in Munich, Germany on November 19, 2002. The speech, "Dynamic Development; Innovation and Inclusion" can be found at http://econ.worldbank.org/files/22048_CES_Munich_Lecture_Nov_19.pdf.

¹¹¹ World Bank, "Cutting Agricultural Subsidies: World Bank Chief Economist Urges Cuts in Rich Country Agricultural Subsidies," November 20, 2002, <http://www.worldbank.org>.

¹¹² United Nations Development Programme, Human Development Report: *Policy, Not Charity: What Rich Countries Can Do to Help Achieve the Goals*, chap. 8, p. 156, http://www.undp.org.np/publications/hdr2003/11_hdr03_chapter_8.pdf.

¹¹³ For more on the WTO Cancun Meeting, see <http://www.fas.usda.gov/itp/wto/default.htm>.

to work with countries to develop strategies to gradually eliminate agricultural subsidies and other barriers to trade.¹¹⁴

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¹¹⁴ Zoellick, Robert, "America Will Not Wait for the Won't-Do Countries," *Financial Times*, September 22, 2003.